HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Madison B. Brown

MADISON B. BROWN

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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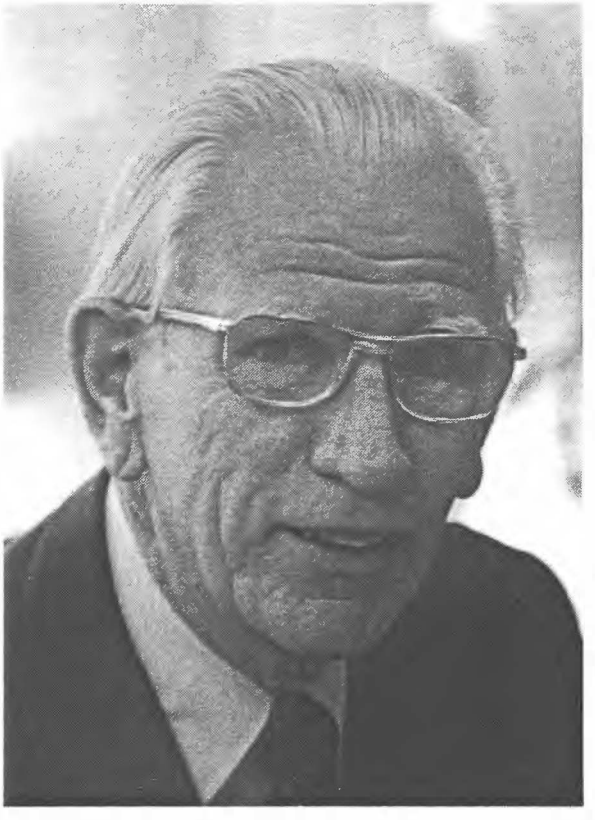
Lewis E. Weeks
2601 Hawthorn Road
Ann Arbor, Michigan 48104
(313) 662-4298



Madison B. Brown

CHRONOLOGY

1911	Born Burlington, VT April 28
1933	University of Vermont, B.S.
1936	University of Vermont, M.D.
1936-1937	Mary Hitchcock Memorial Hospital, Hanover, NH, Internship
1937-1940	General practice in Lanconia, NH and Lebanon, NH
1940-1942	Roosevelt Hospital, NYC, Assistant Director
1942-1945	Military service with 9th Evacuation Hospital. Left service as Lt. Colonel, M.C., and commanding officer of the unit.
1945-1947	Roosevelt Hospital, NYC, Assistant Director
1945-1947	Columbia University, Lecturer in Hospital Administration
1947-1948	Johns Hopkins University, School of Public Health, Associate Professor of Hospital Administration
1947-1949	Johns Hopkins Hospital, First Assistant Director
1949-1953	Roosevelt Hospital, NYC, Executive Vice President and Medical Director
1949-1953	Columbia University, Lecturer in Hospital Administration
1953-1956	Hahnemann Medical College and Hospital, Philadelphia, Executive Vice President and Medical Director
1956-1976	American Hospital Association
	Assistant Director 1956-1957
	Associate Director 1957-1968
	Deputy Director 1968-1972
	Acting President 1972
	Senior Vice President 1972-1976
1959	University of the Philippines and Philippines General Hospital, Visiting Consulting Professor (April-June)
1960-1976	Northwestern University, Instructor
1972	Northwestern University, Department of Medicine, Lecturer

MEMBERSHIPS & AFFILIATIONS

American College of Hospital Administrators, Fellow

American Hospital Association

- Committee of Commissioners to JCAH, Secretary, 1973-1976
- Committee on Hospital Governing Boards, Secretary, 1973-1976
- Committee on Operation of Hospital Planning and License Laws, Chairman
- Committee on Physicians, Secretary, 1973-1976
- Council on Blue Cross and Finance, Secretary, 1963-1965
- Council of Hospital Reimbursement and Prepayment, Chairman
- Council on Professional Practice, Secretary, 1959-1961
- Council on Research and Education, Secretary, 1961-1962
- Department of Administrative Services, Director, 1956-1959
- Department of Hospital Financing & Community Planning, 1963-1965
- Department of Planning & Development, Director, 1965-1967
- Department of Professional Services, Director, 1959-1961
- Life Member
- Special Committee on the Provision of Health Services (Perloff Committee) Co-secretary, 1969-1970
- Special Committee to Review Program for Provision of Health Services (McClusky Committee), Co-secretary
- Trustee 1955-1956

American Public Health Association, Member

Associated Hospital Service. Philadelphia, Member Board of Directors

Commission on Foreign Medical Graduates, AHA representative

Commission on Professional and Hospital Activities (CPHA), Treasurer, 1963-1966; Vice President 1968-1969; President 1970-1971

MEMBERSHIPS & AFFILIATIONS

(Continued)

Committee on Medical Science and Research & Development, Washington, DC
Panel on Military and Field Medicine, Member

Educational Commission for Foreign Medical Graduates, AHA representative, Public Representative, Chairman

Greater New York Hospital Association, Member Board of Governors

Hospital Administrators Correspondence Club, Member

Hospital Council of Greater New York, Member Board of Directors, Member
Master Plan Committee

Institute of Medicine of Chicago, Member

Kansas City General Hospital & Medical Center, Consultant, April 1964

Medical Administrators Conference, Member

Royal Society of Health, Member

Santo Tomas Hospital, Panama City, Panama, AHA-AID Mission, Consultant, 1962

Society of Medical Administrators, Member, President, 1965-1967

U.S. Public Health Service, National Committee on Vital and Health Statistics, Subcommittee on Health Resources and Services, Member

U.S. Public Health Service, Principal Investigator and Project Director of "Collaborative Research in Hospital Planning, W-59"

University of Philippines-China Medical Board, A Study of Administrative Aspects of the Philippine General Hospital, Consultant, 1959

Veterans Administration, Special Medical Advisory Group, Member, Chairman, 1964-1971.

AWARDS

American Hospital Association

Trustees Award, 1966

American Hospital Association

Award of Honor, 1971

American Hospital Association

Citation for Meritorious Service, 1973

American Hospital Association

Special Minute honoring Madison B. Brown, M.D., 1976

University of Vermont Medical Alumni Association

Citation for Outstanding Community Service, 1979

BOOKS

Planning for Hospitals: A Systems Approach Using Computer-Aided Techniques (with Souder,Clark,Elkind) Chicago: American Hospital Association, 1964

WEEKS:

Dr. Brown, in looking at a resume I compiled for this purpose, it looks like you are back home now that you are back in Vermont. I understand that you were born here, attended the University and got your medical degree here.

BROWN:

All of that is true. I was born here and my dad was professor of anatomy and Director of the Mary Fletcher Hospital. I left here when I graduated in medicine in 1936 and didn't get back permanently until we moved here in 1982. In the interim, I came back to see my father and mother and visit the cottage and that kind of thing.

WEEKS:

I noticed that you interned at Mary Hitchcock in 1936 and 1937. Was Jim Hamilton still there?

BROWN:

Jim Hamilton interviewed me when I went to seek an internship. He had gone from there to Cleveland and Don Smith out of Minneapolis, as I recall, was then superintendent at Mary Hitchcock when I began my internship.

WEEKS:

I was wondering, too, when we were speaking of Vermont...I am sure that somewhere along here you have met Dr. John Millis who was president of the university for a while.

BROWN:

Yes, I got to know Dr. Millis, not because he was president of the University of Vermont, but because of his other interests in the field of medical education and later on he was involved with the National Board of Medical Examiners. I was on the board of the Educational Commission for Foreign Medical Graduates, so I used to meet Jack that way. More recently, I have seen him when the National Board for Medical Examiners has its annual meeting, usually in March.

Dr. Millis, having been president of the NBME comes to those annual meetings.

WEEKS:

I talked with him in November or December, I think it was. Also, I worked with him...when I was at the University we had a book publishing press and he wrote a book on pharmacy education which we published. I enjoyed working with him.

I wanted to ask you about Mary Hitchcock, I think that is quite an unusual hospital isn't it, or an unusual setting? I've been told that the physicians there are organized something like the Mayo Clinic. They have a clinic. Is

that true?

BROWN:

The medical staff composes the Hitchcock Clinic. At the time I was there there were seventeen members of the clinic and they also were the faculty of the medical school. Before I left practice in New Hampshire, it had grown tremendously and now they incorporate not only the physicians but some of the Ph.D. members of the faculty.

The unique thing about it is that the clinic itself, when I knew it, was financially independent and not any way financially involved with the hospital. I don't know whether that has changed or not. From my contact with those gentlemen, I got a lot of my philosophy about care of patients, both the social and medical aspects.

I remember we had a young doctor who came from Bellevue. Dr. Gyle, who was one of the surgeons, heard him being unkind to a patient. Dr. Gyle said, "Young man, we don't speak to our patients that way and, by the way, he could buy us all out. Just because he is in the ward doesn't mean he is a nonpaying patient."

WEEKS:

There was that feeling, as I understand from talking to Hamilton. He also mentioned the fact that the medical school was almost too heavy a load for the university to carry. Is it still a four year school?

BROWN:

In those days it was a two year school. It is only comparatively recent that it has become a four year school. I think all of the universities and colleges that have medical schools find out that it's probably one of the most expensive branches of education that they can become involved in. So it is

financially a burden to whomever sponsors it. It's true here and it's true at Mary Hitchcock and Hopkins.

WEEKS:

You were in private practice for three years. Did you enjoy that?

BROWN:

I enjoyed it but I had inclinations to do administration and so I fell heir to a couple of articles, one by Dr. Claude Munger, who was then at St. Luke's, New York, and another one by a man in Boston. The articles discussed the training of people in hospital administration.

I talked it over with my father who was director of the Mary Fletcher Hospital here in Burlington and he said, "If you want to try it go ahead, but don't come here." And I understood what he meant.

So after planting my name with the American College of Hospital Administrators, Dr. Clemmons, who was then director of Roosevelt Hospital in New York City, contacted me and after we negotiated for about four months I went there as his assistant director.

WEEKS:

You were there until you had to go to military service...

BROWN:

That was a rather interesting day because when Dr. Clemmons and I met after Pearl Harbor, he said, "Well, this is going to change things at Roosevelt because I'm going to sign up."

I said, "Dr. Clemmons, that's a little ridiculous at your age, you had better let me go."

So Roosevelt Hospital sponsored an affiliated unit and we organized and staffed the professional and nursing side of a 750 bed evacuation hospital. I

started in as the registrar and ended up as the commanding officer.

WEEKS:

I have just a hazy idea of what an evacuation hospital is.

BROWN:

The 750 bed evac had a staff of thirty-seven physicians and five other officers, fifty-two nurses, a dietitian, and later on we were the first hospital to use Red Cross gals in the hospital. We were all under tentage except in the winter time when we purloined some school or abandoned military buildings to get out of the harsh weather. General Patton developed a 400 bed evac; it had its own vehicles so that they could move their own equipment and personnel. To move we used quartermaster trucks. It took 110 trucks to move all our equipment, tentage and people.

The colonel, our commanding officer, was an inherited man. I say it that way because he was assigned to us. He inherited Roosevelt Hospital's people. He talked with me about it one day and thought the officers were "anything for a party."

I said, "Colonel, don't worry about them. If you get anxious you talk with me and I'll straighten it out because these people I have worked with."

He said, "Okay, you have just volunteered to be responsible for moving the nurses every time we move." So I moved fifty-five women wherever we went and watched out for their luggage and other things.

WEEKS:

That was quite a lot of moving.

BROWN:

When we got into Africa -- it took about six months before we really got rolling. After we got rolling -- ten days to three weeks would probably be

the longest time at any site. So we were tearing up and putting down and taking care of patients. When they—thought that the Germans had made a successful venture through Kasserine Pass, we got the word that we had to move to the rear and PDQ. Of course, the Germans didn't make it to where we were but in that twenty-four hours, we admitted and discharged 508 patients and we had to leave one tent behind for the patients that had just been operated on and they couldn't be moved.

WEEKS:

Yes. That was pretty bloody fighting there too.

Now I have a better picture of evacuation hospitals.

BROWN:

Just seeing them all under tents...a ward tent was twenty by sixty feet, heated in the cold times with a potbellied stove which had a kerosene heater unit in it. It could put off the BTUs, I'll tell you.

WEEKS:

At least you had enough heat to keep you warm.

BROWN:

Evacuation hospitals were well taken care of...lots of blankets, mattresses, the pillows took an awful beating. Being a hospital unit, of course, our rations were very good, so we were popular with correspondents and anybody moving on, who didn't have to get to his unit, usually stopped with us for a meal.

WEEKS:

In looking again at my notes you returned again to Roosevelt in 1945 after the war. I have talked with various persons who have said that physicians attitudes changed after the war in the sense that they expected more. They

wanted to practice differently. They didn't want to go back to what it was like before the war.

BROWN:

As I recall, at Roosevelt Hospital, there was some feeling between those who had been in the unit and those -- and I'll put it this way -- who had to stay. But the boys who worked for "Uncle" three years plus, held it over the others a little bit. However, the older staff were very careful to keep it from becoming a schism in the staff -- I was a member of the Roosevelt unit and you weren't.

WEEKS:

I wondered if the physicians who came back had found that the military hospitals gave them a different kind of support than the hospitals back home. Was their position or their role different in a military hospital -- different enough so that they would be dissatisfied with what they came back to?

BROWN:

Not in my experience. It may have been in other institutions. Roosevelt Hospital had a long tradition of its chiefs of service being well selected. They were senior in age, they were senior in clinical abilities, and they were appointed by the Board. So you had a framework in which it was pretty definite that the chiefs of service were responsible for their services. Underneath you are going to get the newer members who come on the staff anxious because, "I went through more training than he did," or "we found this out in our experience in North Africa or Sicily or Italy or France or Germany." However, once this was known, then the chiefs of surgery who were not in the unit said, "Okay, what do you want to do about adopting it in our service." Administration's attitude, as the board's was, within rhyme and

reason, what do you want to do?

WEEKS:

So then there were some changes that were suggested that got a fair trial.

BROWN:

Probably the most significant change after World War II was the change in the graduate medical education programs. Before World War II, Roosevelt Hospital's training programs were houseships and a houseship in medicine was three years and surgery was four years. After World War II, the specialty boards were coming into their own. I talked with the medical board and said, "Gentlemen, we had better catch up with the times and we should program our training so that our residents, when they finish, will be board eligible, or they can take more training if they want some other specialty."

It was interesting, some of the men at Roosevelt were boarded, others -- and the prominent in the medical staff -- were not boarded and they didn't see any reason to become boarded. I said, "You can live through it but the residents can't. They are going to be judged by their specialty boards when they either want to come here on our staff or go to live somewhere else and want hospital privileges. Part of their ability will be, are they boarded?" It has become very common that that is the signal to look for, whether the man is a board specialist is as important as does he have a license -- even more important than what medical school, what hospital did he take his training in. All of those things get a very keen, cold fish-eyed look when selecting staff.

WEEKS:

You were an M.D. in a hospital administration position. This was more common then than now, wasn't it, that physicians were heads of hospitals?

BROWN:

Very much so. You see, when I started out, the Boston area was probably the one where most administrators were physicians. In New York City where I started, quite a number of the institutions, but not necessarily the largest, had physicians.

In the schools in hospital administration (now with other kinds of titles of health care administration and the rest) often the chief professor of the course was a physician. I taught at Columbia and at Johns Hopkins, and did some teaching in Chicago at Northwestern University and the University of Chicago.

Right after the war, there were a lot of physicians who had been in administrative posts in the military who wanted to come and get the credit for having completed a course in hospital administration. That lasted about five years then thinned out and after that the majority were non-M.D. The number of physicians who are the chief executives of our voluntary non-profit hospitals are really rather small. The larger number of CEOs in hospitals of all sizes are non-MDs.

WEEKS:

The very fact that we have so many good schools of hospital administration or health administration probably has something to do with it.

BROWN:

Kellogg sponsored probably the first fourteen of the programs.

WEEKS:

Yes. I know they had a great deal to do with Michigan and others before Michigan. Michigan came in in the middle '50s and I guess Chicago goes back to the '30s, doesn't it?

BROWN:

Yes. In 1940, the person I replaced at Roosevelt was a course graduate with Dr. Bachmeyer in Chicago.

WEEKS:

You said that you lectured at Columbia. Was your title Lecturer?

BROWN:

As I recall it was. Dr. Claude Munger was the professor of the course and when I taught there I inherited Dr. Robin Buerki's course on medical staff relations.

WEEKS:

Was he in the New York area at that time?

BROWN:

He was in Philadelphia.

WEEKS:

Tell me something about Dr. Claude Munger. I have heard about him from Klicka, I have heard about him from American College of Hospital Administrators history. He must have been a remarkable man.

BROWN:

Claude was a bachelor. In his own environment, he was somewhat of a martinet, but his knowledge and appreciation of all of the people that worked in the hospital was exemplary. Roger DeBusk was with Claude for a while. Everyone learned from him that the effective chief executive officer must have great empathy for the physician and the nurse, and all the others represented within the staff.

Dr. Munger was one of the presidents of the American Hospital Association. I don't remember the detail, but he was a bit miffed with the

National League for Nursing and some of their philosophy. St. Luke's had one of the hospital schools of nursing, as did Roosevelt, and he really appreciated the capability of the nurse as produced by the diploma schools. Of course, we are talking about an entirely different era of nursing. Today the emphasis is on the baccalaureate degree programs.

WEEKS:

I have heard several people speak of Dr. Munger as being very knowledgeable and being a great teacher. Karl Klicka spoke about working under him and the advice that he didn't seek when he should have sought it. Was Raymond Sloan at Columbia when you were there?

BROWN:

Yes. Ray and I came to know each other quite well. Ray cautioned me that I shouldn't provide an office for the president of a hospital within the environment and I said, "Ray you don't know Mr. D___." Ray was a very strong leader in the course.

WEEKS:

Maybe you can tell me how you happened to move to Johns Hopkins.

BROWN:

I was on an ACHA committee looking into the educational pattern for hospital administration and the discussion of the then-called internship year. At that time, I met Dr. Crosby who was the director of Hopkins. Ed and I had talked frequently about the committee's work. He needed an assistant. So he talked with me, in fact, both Ed Crosby and Russell Nelson talked with me. That was an interesting situation because they wanted me to be their course director. I said I'm not interested in being a course director. After we batted it around in exasperation, they said well what are you interested

in? I said I'm interested in administration. They said our best post here is director of the clinics. I said no dice. I want to work at the top level with you Ed, so it finally worked out that way and that's how I got from Roosevelt to Hopkins.

WEEKS:

Was Jim Hague there at that time?

BROWN:

Jim Hague was at Hopkins. Ed brought him in for public relations.

WEEKS:

He had been working on the Washington Post prior to that. But you did teach in the University as well as being on the administrative level of the hospital.

BROWN:

Yes.

WEEKS:

You went back to Roosevelt in 1949.

BROWN:

Yes. Dr. Clemmons became ill and Mr. Dominic asked me if I would come back and I said I would be very pleased to come back to Roosevelt. They asked me then to come back as executive vice-president.

WEEKS:

In a big hospital such as that was, being executive vice-president, how much did the board enter into the running of the hospital? This has been one of my favorite topics. Was it a rubber-stamp board or was it a working board?

BROWN:

The Roosevelt board was large -- it was 33 and got to be 37 before I left

there -- with an executive committee of about twelve. The main committees were the finance committee, executive committee, and building committee and then there were some others that didn't have very critical roles. I had talked with Mr. Dominic and told him that I felt that the chief executive officer's obligation to the board was to be responsible for all the environment and my success in handling that was really what they ought to judge me on. Also, I felt a responsibility to work very closely with the medical staff, and that for the medical staff on appointments and administrative matters I would make that kind of reporting to the board, though later on we had officers of the medical staff sit with the board. I had a very strong feeling that if the environment is done correctly, except through committee approaches, the board does not and should not be involved in the administrative thing. We had a change in presidents and the gentleman who came in soon started making a tour of department heads. I took exception to this and the former president straightened it out. What the new president should have done was come to me, in my philosophy, and say he would like to know more intimately about what goes on in the hospital. That's fine. I would be his host and we would go around and visit people.

It's difficult, in my experience, if the board actually has to get in to do administrative things that the chief executive should be held responsible for. There are some who have difficulty in what you do about the medical staff...let the board handle their problems. My philosophy is that the chief executive officer handles overall administration -- he works closely with the medical staff. Medical staff and the chief executive officer get their ducks in a row and then make a presentation to the board so that they do not have to handle continually the difference of opinion between the CEO and the medical

staff.

WEEKS:

They make policy decisions but you make operating decisions. I have heard of hospital administrators who hate to see their board members wander in and wander around, as you were saying, without working through the administrator, working with him. I understand they want to know how things operate but they should do that through the administrator.

BROWN:

It was interesting, when I came back to Roosevelt, they had a party to greet me and the president said, "Madison, we are glad to have you back aboard."

So when it came my turn to comment I said, "Thank you for using that nautical term because it fits in with my philosophy about our relations, speaking of the chief executive and the board -- the board are the representatives of the community -- in house they are super cargo which means that anything you want to do and know and see, please come and talk with me and we will work it out. But to go and try to find out how the boiler is fired and a few other things like that makes it difficult for the department heads to know to whom do they report."

WEEKS:

That would seem a necessary situation that everyone should understand but I'm sure they don't all understand it.

BROWN:

We found this out at AHA when we were doing the management surveys. You often find institutions in which the environment is very brittle -- and, of course, we did a survey with the administration elements, with medical staff

elements and with the boards. Usually the over-anxious and overt trustee would reveal that he wanted to go around and talk with this one and look into that. Our interviewers had been schooled to look and say, "Is that the way you run your plant? It is just the same kind of environment, you don't want somebody coming in and doing your job in your plant." They would see it then.

WEEKS:

They would understand it when it was in business terms.

BROWN:

It's not that you want to keep your trustees out of the hospital, but under appropriate relationships so that the people in the hospital know who is the CEO.

WEEKS:

That is very important, it would seem to me, and I have never been an administrator...but it would seem to me that that is right.

You were at Roosevelt before the union organizing, weren't you? That came in the 1950's. You were in Chicago by then, I guess. I had an interesting interview with Leon Davis the man who started 1199 back 50 years ago. A very impressive man. He said something that has proved itself in the past few weeks. He said we did our organizing first -- he was a pharmacist and so they organized the pharmacists first -- then they organized the dietary people and the housekeeping people and all the people who work in the services. But he said we found that in order to shut a hospital we had to have the nurses in the union. Look what they did in Seattle or somewhere out west where they had the strike with several thousand nurses out, fifteen hospitals. He was talking about that and it has come to pass.

I have a couple of other notes on your New York stay. Were there two

organizations, the Greater New York Hospital Association and the Hospital Council of Greater New York? Were they one and the same?

BROWN:

The Greater New York Hospital Association was the organization of the administrators or executives of a hospital. The other was the planning council. John Pastori was the director of it. I was part of that board. These were in the early days of planning and the utilization of Hill-Burton funds and the approval of the projects. The master plan got to be a dirty word for a lot of people. I never objected to it because the master plan had categorized the institutions. The result was that hospitals also knew what their mission was and what services they had and how they were fulfilling the plan for that area of New York. Roosevelt had a lot of latitude. I used it with good success at Roosevelt because it designated us as a regional unit and we always had more to do than we had money for.

WEEKS:

George Bugbee was in New York about this time too. He did't go to New York until after you left Roosevelt, I guess.

Then I have the next step here that you went to Hahnemann in Philadelphia.

BROWN:

Yes. Bob Buerki had suggested that they contact me. I went to Hahnemann and was there from 1953 to 1956.

WEEKS:

Was that originally a homeopathic hospital? He was sort of the father of homeopathy in this country, wasn't he?"

BROWN:

They borrowed his name.

WEEKS:

He wasn't an American, he was German, wasn't he?

BROWN:

That's right. He is said to have helped establish a hospital in Chicago.

WEEKS:

Years ago I was a detail man for a chain of prescription stores and I discovered a few homeopaths. They were still around back in the 1940s.

BROWN:

Hahnemann was sticking with it and had a course in homeopathic therapeutics. There was a fairly sizable chunk of money that was supposed to come to them if they were still homeopathic. Really in the way homeopathy functioned it didn't make much difference anyway.

WEEKS:

So it just sort of died out by itself. We had a homeopathic school in Michigan at one time back years ago. The building is still standing.

While you were at Hahnemann, is when you were the AHA trustee?

BROWN:

Yes. I had just gotten to be a trustee then I left Hahnemann and went to AHA on the staff. So I was only trustee for a year.

WEEKS:

You also served on the Blue Cross board at that time too didn't you?

BROWN:

I was on Mr. van Steenwyk's board in Philadelphia.

WEEKS:

Yes. Norby told me some great stories about Mr. van Steenwyk. I guess he

was quite an innovative promoter.

BROWN:

He was that and he and Rufus Rorem used to work out how much they were going to pay the hospitals in Philly and then you would get a notice to come to a meeting and we will tell you all about its approach.

One day Van said to me, "Gee, you are doing wonderfully, you control the expenses."

I said, "You aren't paying me enough to take care of the institution, that's why my expenses haven't gone up."

WEEKS:

Was Rufus in Philadelphia at this time...he was in Philadelphia in the Planning Council or whatever it was called. Bob Sigmond, as a young man, was working there too, wasn't he?

BROWN:

Bob was with the council and then up at the Jewish hospital.

WEEKS:

He was at the Jewish hospital in several capacities. That was when the administrator was Lucchesi.

BROWN:

Yes. Pat Lucchesi was director of Philadelphia General. Then the board selected him up to run Albert Einstein Medical Center.

WEEKS:

You went to Chicago about the time Dr. Crosby took over, didn't you? He was maybe a year or two ahead of you.

BROWN:

Yes, he was. Before that he had been director of the Joint Commission on

Accreditation of Hospitals. He came to AHA when George Bugbee left.

WEEKS:

Your title originally was assistant director of AHA?

BROWN:

I passed through all the titles that they could think of.

WEEKS:

I noticed during this early period that you were director of the department of administrative services. What does that entail?

BROWN:

The department had design and construction, accounting, general administration, housekeeping, laundry as functions to keep an eye on.

WEEKS:

Was this the time when you were doing your book or did that come later? That was in the '60s, wasn't it? That must have been about 1964.

BROWN:

The book was published in 1964.

WEEKS:

You came to this administrative services with a background of planning which you had in New York which must have been very helpful.

When I talked with McNerney, we were talking about pre-Medicare days and I don't know the exact year that Walt went there to BCA but it must have been in the middle '50s or as late as '59 or '60 -- but one of the things that occurred to him was he said there was all this pressure for what we call Medicare today and he was wondering what the condition of the aged was. Was there a formal study involving BCA and the AHA in which the two looked at the condition of the aged and their needs, their health needs?

BROWN:

The way I remember it was that hospitals had become aware of the costs of the aged -- quite aside from the real problem of the indigent. Blue Cross was sponsored by AHA so you had our paying arm and our operating arm concerned about this. Both felt that something should be done about financing health care for the aged. How formal the study or how we conducted the analysis, I can't remember.

WEEKS:

But you were both quite conscious of the need to know more.

BROWN:

Yes. Also, for a long time there was a dichotomy between the thinking of the American Medical Association and the American Hospital Association as to how to do it.

WEEKS:

It seems to me that McNerney said to me that he came into the BCA and this was one of the things that he tried to approach with AHA was, to try to find out what the needs were and so forth. And then apparently somewhere along the way the news media got some whiff of this and I think that McNerney or someone made a statement to the effect that possibly there would have to be some other coverage for the elderly people. This was picked up and was run as a fact that Blue Cross was going to offer some special coverage as a result of which someone called one or more of the local Blue Cross plans and said what is the policy and whoever answered the phone said, "We don't know what you are talking about." Which made a very embarrassing situation. Do you remember anything of that sort?

BROWN:

No, I don't recall the details.

WEEKS:

When John Mannix talks about his early days in Blue Cross and talks about how they would set a rate — well they sat down and said they would mesh some figures together and find the average person spent so many days a year in the hospital or whatever and the hospital costs so much, so by simple figures, if they added 10% or 20% as a safety measure, then they had a going rate. It was that simple in those days.

BROWN:

And Mannix would know because he lived through it all.

WEEKS:

He is still living through it.

BROWN:

He is one of the most remarkable men. He probably ends up by being the most thoughtful man, in my opinion, involved with Blue Cross.

WEEKS:

I agree to that.

BROWN:

There were a lot of giants in Blue Cross when I went with AHA. I don't know the field now so I couldn't make any comment but McNerney, Doug Colman, Mannix and van Steenwyk were thinkers, and philosophers. They considered themselves real social leaders.

WEEKS:

It was a social movement, rather than an insurance plan really. Many of those prepaid plans -- they didn't all end up being Blue Cross, there were

others such as Kaiser — were a revelation to the people that they could prepay for hospital care, some cases even of medical care. As I remember, before Blue Cross, when you talked about health insurance, it was sickness insurance. If you are out sick, it would cover the wages of the wage earner. This is about what it amounted to.

Your next move, you have moved up to the title of Associate Director of AHA. I was wondering what you did as Director of the Department of Professional Services.

BROWN:

Here I was getting more involved in AHA staff representations with the AMA and the Association of the American Medical Colleges. Another thing we were interested in was organizing the committee on physicians. It has really taken off and is now a council. The relations with any of the professional societies. I used to go to...

WEEKS:

I think that you took a trip to the Philippines in about 1959.

BROWN:

The China Medical Board made a request to Dr. Crosby to find someone to go and make an administrative survey of the relationship between the Philippine General Hospital and the Philippine Medical School. They wanted the person to stay for six months. So I gave Ed his class A++ roster and I said, "My gosh, not Russ Nelson, Ray Brown, nor anyone else can pull himself out of his job for six months — maybe even three months is difficult for them." "Well," he said, "okay."

I didn't hear any more about it for about three or four days.

Finally, he said, "How about you going?"

I said, "That's for you to decide how long I would be away but," I said, "there is one hooker. I want to take Vernon with me." She was public information officer for Passavant Hospital. I don't know how it was set up, but Mr. Edison Dick, President of Passavant, and Vernon's boss, finally agreed. We were gone about three months.

WEEKS:

First or last name Vernon?

BROWN:

Vernon is my wife's first name.

WEEKS:

Oh, I see, that's wonderful that you could go together. Is her name Verna or Vernon?

BROWN:

Vernon, not male this time. John Hatfield was her boss. Incidentally, he was a former president of AHA.

WEEKS:

I have heard his name. And Mr. Dick was the mimeograph person?

BROWN:

That's A. B. Dick, yes. He was a member of the family and on the board.

WEEKS:

The Council on Professional Practice that you served on at that time — was that different from the professional services department?

BROWN:

You see, AHA's structure for membership involves members of the association in the committees, then the councils, then the Board. The House of Delegates is more complex today with several types of membership

representative of the constituencies of AHA.

The Council on Professional Practice was treating with issues of medical staff relations, we also had a committee on infections which was a very excellent one because it had a lot of the people from Atlanta on it. It did some of the early work on the preparation of manuals for use in hospitals.

WEEKS:

I have always been a little confused about this. The councils are not ad hoc, they are established, aren't they?

BROWN:

They would be standing.

WEEKS:

Do they report to the House of Delegates?

BROWN:

They report to the General Council, it reports to the Board, and it in turn to the House.

WEEKS:

How was some action instituted? Say if the council investigates something -- how is that instituted?

BROWN:

They have a nice terminology for the action which they want the General Council to consider. It is a "voted to recommend" that such and such be done. When it comes before the General Council or Board it is either accepted or returned or it may be turned down. If the action were, let's say, to prepare a manual on infections in hospitals, after the idea is approved, it goes back into the staff and through committee or advisory structure to create the manual. Then it comes back to the General Council and Board. After the

manual is approved it is referred to the House. Anything that is policy for the Association has to go through the House. Now the Board can go at risk -- stick its neck out -- on policy and then have it confirmed when the House meets, which it does twice a year.

WEEKS:

The Board has power to act between Board meetings if necessary. Then a department itself is part of the regular organizational structure.

BROWN:

Yes. When I first went aboard at AHA, staff was identified as Secretary of the Council on Administration or as Secretary of the Council on Professional Services or secretary of this committee or that. For some of the staff it seemed like the persons they must please should be the chairman of a council or committee. Dr. Ed ran into a few problems with some of them.

I said, "Ed, you've got to have another harness. We need an administrative hierarchy and the secretaryships which you may appoint are just an extra post, an honor, to that individual."

He said, "Okay, wise guy, you set it up." That's when I made the first administrative chart and outline. I was, for instance, the director of the department of administrative services.

He first looked at it and said, "You've got directors all over this chart."

I said, "Yes."

He said, "There is only one director."

I said, "Yes, that's right, you're the Director."

I added, "Nobody's confused. You don't use my directorship without identifying it, Director, Department of Administrative Services."

After I left, they created a whole new terminology and hierarchy and

arrangement.

But at that time, you were part of Crosby's staff and you knew it. If you got to be a secretary, you didn't abuse the privileges because you could get hatcheted if you thought you could use your chairman to do something you wanted done in the hierarchy.

WEEKS:

Was it during Crosby's tenure that the regionalization came in where seven or eight regions...

BROWN:

When we first started there were nine. This was to get an administrative mechanism to assist the states. AHA was instrumental in the development of state hospital associations. Later the metropolitan and some regionals were organized. We were interested in developing a mechanism of AHA to assist the states and that's why the regional offices were formed.

WEEKS:

As I understand it, each regional has a representative on the House of Delegates.

BROWN:

Oh, yes. The states have delegates and that is one kind of a mechanism which is all done according to the dues. And then also added to the House are representatives from the regions, one of them being a physician, another a trustee and I don't know what all the detail is now.

WEEKS:

How does AHA work then? Does it depend on everything coming up through council? Can something be originated at the top? Can something be originated in the Board and then passed to the delegates?

BROWN:

Yes.

WEEKS:

Then it is flexible in that way.

BROWN:

Yes. When we would have our annual convention, the meetings were not exciting because anything that flowed from committee to council to Board and eventually to House was well churned and well discussed. And before any of these House meetings we took pains to go out through the regional offices and explain what we wanted and what was going on. Then there was a "hearing" session before the House meeting at which anybody who wanted to come could discuss any problem.

Pretty much AHA's agenda for the House had grown up from within, there were very few surprises. Everybody was very conversant with what was going on.

WEEKS:

So there was nothing sensational for the press. It was pretty well decided before you get there.

BROWN:

And they have a hooker on it, if somebody wants to put in a resolution, the Board desires to have it put in ahead of time and get it exposed.

WEEKS:

Nothing can come from the floor.

BROWN:

Yes, it can, there is opportunity, but the procedure is carefully controlled by the Speaker of the House and the rules of the House.

WEEKS:

I have you as Secretary of the Council on Research and Education about this time too.

BROWN:

This was one of the newer ventures. We didn't really know what ought to flow through it. I was kind of the handy man for Ed so I started off as one of its first secretaries.

WEEKS:

The original, I mean from George Bugbee's time, the research that they were doing then was in operations, wasn't it, so that they could write the manuals and get information out to the hospitals? Was this about the time that HRET was formed?

BROWN:

I have forgotten the date when HRET began. The reason for it was AHA wanted some Kellogg money. Kellogg says we're impressed but we can't give you the money. You are a 501(C)6 not (C)3. It didn't take too long to get the HRET with a 501(C)3. That's how the Association can channel funds from certain organizations.

WEEKS:

I was wondering if you had any influence on HRET?

BROWN:

The boards are overlapping.

WEEKS:

Yes. The president of the one is usually the president of the other.

BROWN:

They interlock but HRET's board is smaller.

WEEKS:

I also have you down for the Department of Hospital Financing and Community Planning.

BROWN:

This was all getting into the early days of moving from master planning with which I was involved in New York to what they considered a much more sophisticated procedure with staffs in planning in institutions. So really I was the management head of it and I have forgotten right now what kind of staff we were using but, of course, we had a staff architect and several other people.

WEEKS:

Was this the time when you did the work with Souder? I think the book has a '65 date or '64.

BROWN:

Yes, '64. The work was done in 1962 - '63.

WEEKS:

I met him. Wasn't he at Silver Springs about that time with the government...an office in the government?

BROWN:

Souder was at York and Sawyer in New York City when we did the project. He was the one who was particularly interested in this project.

WEEKS:

This was pretty early on for using computers in planning.

BROWN:

We had one study before this, a feasibility study on the use of computers that we did in 1958 with John Diebold and associates at Baylor Hospital. The

computer people in the computer assisted planning study were from Bolt, Beranek and Newman. They were Clark and Elkind.

We used a PDP-1, I remember. A little giant. You had to write the program. It had an administrative core for its functions. But any study you did you introduced the tape and you updated.

The room that it was in was about the size of this office. Staff was using this computer twenty-four hours a day in order to get their studies done. The uniqueness of this study was the concept of time and movement of people and things.

WEEKS:

I wanted to ask you about your activities pre-Medicare in helping get this bill ready and through Congress.

BROWN:

The majority of AHA input to Medicare legislation was done through the Washington office, Kenny Williamson and Dr. Crosby, and, at that time, two of the president officers. I was not involved in this until after passage of the legislation and then I was very much involved in screening regulations, talking with the Social Security Administration staff about reimbursement and the reimbursement formula.

WEEKS:

By this time AHA and Blue Cross had been separated, hadn't they? So as we mentioned at lunch, there could be no conflict of interest particularly because you were separate and could support the Blue Cross Association and various plans as fiscal intermediaries.

BROWN:

We administered the vote of the membership for intermediary hoping they

would vote for Blue Cross.

WEEKS:

THat was a very high percentage wasn't it?

BROWN:

Yes. I can't remember, but it was above 70%.

WEEKS:

I was going to say that it seemed to me it was up in the 80s somewhere.

One thing we surely want to talk about is your experience with CPHA, the Commission on Professional and Hospital Activities. In this corporation, AHA had a seat on the board, is that right?

BROWN:

AHA had two seats. All of the sponsoring organizations had representation and it had been Dr. Crosby's decision that we would use one member of the staff plus one from membership at large. That resulted in my being on the board for quite a good number of years.

WEEKS:

As an officer from '63 to '69.

BROWN:

I was on CPHA from 1959 to 1976. Was president in '70 and '71, the executive committee '61 to '72, vice president '68 to '69, committee on permanent location in '66, treasurer '63 to '66, special committee on marketing and research in '68.

WEEKS:

When CPHA was originally set up, it was set up, as I remember, as just a small organization in southwestern Michigan. As it developed it became evident that there might be a lot of data collected that would be useful to

people for management studies, for research, for many purposes. The idea was to get subscribing hospitals to agree to submit data on discharge which would cover patient and care characteristics such as age, sex, diagnosis, final diagnosis and many other things.

BROWN:

Each discharged patient had a case abstract.

WEEKS:

My understanding was that when Kellogg thought that it was wise for Dr. Vergil Slee and the people who had started this — when they decided to go national so to speak — that he thought there should be a governing board set up of representatives from different professional groups which included AHA, of course, and AMA and the College of Surgeons and the College of Physicians, and, for a while, even the Canadian Hospital Association were in for a short time, weren't they?

BROWN:

As I recall, the Canadians were more involved with the Joint Commission on Accreditation of Hospitals.

WEEKS:

What was your conception when you first...what was your understanding of the purpose of CPHA in collecting this data. It was heavily supported by Kellogg for many years and they bought a beautiful piece of property and built beautiful quarters and invested quite a lot of money in computers and then finally, didn't they sign a contract with Ross Perrot in Phoenix?

BROWN:

I don't know if they ever did anything with Ross Perrot or not. The decision to stay in Ann Arbor was one that was debated among the sponsors and

CPHA, and the building was built in Ann Arbor and it was done with some assistance from Kellogg but otherwise it was a mortgage.

Now when I first went into it, there were two facets of what CPHA was doing. One side was the assistance to the medical staff as well as nursing staff about patient care. The other was -- throwing it all together -- the quality of care in a sense performed by the medical staff which administration should be interested in. The difficulty for administration in using the information was that the format was basically for perusal of quality of care by medical staffs and not by administration. So it never caught on very well at least with administrative types.

WEEKS:

I think at lunch you did make a statement that you thought maybe if they had some kind of way of publishing this data for administrators' use....

BROWN:

What you do is make a summary sheet of denominators of interest to administration as a separate report.

WEEKS:

What was the trouble? Why did CPHA finally get into financial trouble, other than their grants drying up from Kellogg?

BROWN:

Long, long before that -- I think the last Kellogg money that I am aware of was the money which they put into the development of the headquarters building. I don't know the details of the final financial outcome but the numbers of subscribers had fallen and so my supposition is that business fell off so that they couldn't finance it.

WEEKS:

Do you think this was due to what we mentioned before, the inability of people to use it who might want to use it?

BROWN:

The whole business of auditing and assaying the quality of care got to be everybody's business and the issue with CPHA was to gather its data so that the reports could be used for supporting the hospital's answer to the Joint Commission or to PSROs or to anybody else — and they were slow in doing that.

WEEKS:

So it was a case of not getting ready for the market that was probably there. Then, of course, there is the possibility that they overexpanded in their building because they not only built that new building in that beautiful park that they bought, they also bought a building adjoining it. I can remember being there when they were using about half of it (the second building) and were renting the other half out. It would seem to me that they were real estate poor there for a while.

At the time you were there were they talking about the computers they had purchased back in the '60s...I think they were Honeywell...and they were outdated before they got them paid for. Did they ever talk about that?

BROWN:

The only thing I remember about the computer battle was the majority of production in the hospital industry was out of IBM and their products were not necessarily compatible with Honeywell. To his credit Vergil was one of the very successful users of computers and they were one of the first to use optical scanning. They knew what they were into and how they did it.

WEEKS:

It seems to me that this Honeywell purchase was quite a load on them because they were soon outdated -- outdated before they could pay for them. And I think they did have a contract with Perrot's outfit, which someone said was not a very good contract for CPHA.

BROWN:

That was after my time, I didn't know anything about it.

WEEKS:

Since you left, I think they have tried to combine marketing, at least with HAS from AHA. There have been some rumors that maybe someday they will set up a separate corporation and combine the two.

BROWN:

There were repeated studies on how to utilize HAS data and CPHA data. The great difficulty you have is that CPHA's information is based on individuals. HAS is done on the hospital experience so you are talking about the department of laundry, and not talking about individuals, but talking about group dynamics. So it's difficult to utilize elements of data from each one that would be useful to anybody.

WEEKS:

Another thing that someone brought up, I think it was John Mannix, was that he had done some studies in collecting data from seventeen counties in Northeast Ohio or the Cleveland Blue Cross plan -- I think they have practically all if not every hospital in that area as Blue Cross affiliates -- and he is able to get regional data. If you say of all of the people who go to the hospital in northeastern Ohio this, this, and this happens. Where CPHA says out of a sampling of 2,000 hospitals throughout the country, this,

this, this happens. The question arises which is more valid or is there any difference and so on. I think the field is changing so rapidly.

BROWN:

The basis on which Blue Cross plans reimburse, their detail will show the profile of an institution, it will also throw out profiles of individual practitioners.

WEEKS:

Another thing that is changing is the hospital chain. Some of them are developing their own data systems for studies and so forth. As an example, I think I remarked to you that in April I interviewed Dr. Frist from the Hospital Corporation of America. When he was speaking about a $40 million computer system they were going to put in place so that they would have a profile based on 56 or 57,000 beds that they have in that system, either owned or managed. This may be a different type of competition for CPHA.

BROWN:

More and more hospitals, you see have had to modify their business systems to produce information for Medicare. It has become the master. However, the systems also had reasons to compile data and information of use to that system. So as they jokingly say we've got a government report and we've got our report.

WEEKS:

This seems to be changing the whole picture here today. CPHA has a lot of problems just in the change of demand as well as need.

Did you work with Al Manzano, was he with AHA when you were there? Later he was managing CPHA, then went to the Washington office of AHA.

BROWN:

He was in and out.

WEEKS:

He has now left and gone to California, hasn't he? Someone said that his family is all out there and he is very close to his family and wanted to live in California.

BROWN:

Actually, when he came to work with us first he was out in California and he had also worked in the federal government.

WEEKS:

He was succeeded at CPHA by a man named John Bassett. Did you know him?

BROWN:

I don't know Bassett.

WEEKS:

Incidentally, I understand that he had a stroke about a week or so ago and he is a man I don't think more than the middle thirties. Apparently was doing a very fine job. I haven't heard how his progress is.

You left AHA in 1976. You were still there when they were doing the ICD-9-CM, the coding book, at CPHA, weren't you? What reading did you get on that as far as the government was concerned? Let me tell you what I think I know, and what I don't know. My understanding was that the government would not adapt their latest code book to meet present needs as Vergil Slee saw them. So he decided to go ahead and he spent two or three hundred thousand dollars making a study of what needed to be done and in setting it up. And then he still didn't get any support from the government so he went ahead on his own with the idea that he could sell these coding books at a profit which

would pay off the preparation expense and possibly, if things went well, he might be able to accumulate something in escrow which could be used on the next revision whenever that might come. Am I somewhere near the facts on that?

BROWN:

Well, you see, within AHA we had the expert and the major consultant to the government on terminology and Vergil was always miffed at us that we still did do that and didn't just back his interest. Among Blue Cross plans, some endorsed one terminology and some endorsed another. You were walking the tight line between what book somebody wanted to use and what somebody had to use. But what you just cited happened after I left.

WEEKS:

I originally attended a meeting -- it must have been in 1976 -- at which it was discussed. They had a lot of people in to discuss what should be done and get various ideas and then combined those or selected what they wanted. Then later came the publication effort and the checking and the typesetting and all of which was a terrific headache. But it must have been 1977 or '78 when they brought these three volumes out and I think they were right in the sense that a standard code book was needed.

BROWN:

We encouraged the federal government to use Vergil as one of our representatives in Switzerland and to give him an opportunity to discuss his thoughts and philosophies. But he didn't win a lot of the battles and so his book wasn't the one that was official.

WEEKS:

This was on the international scene. The one the government had put out a few years before this had been an adaptation of a former one, hadn't it?

BROWN:

Based on the international.

WEEKS:

Here again, Vergil was stepping out and doing a ICD-9-CM which was a so-called improvement of the federal government which was an adaptation of the international. So we really had three didn't we? So, by the time you left AHA...

BROWN:

As I recall, it hadn't been crystallized.

WEEKS:

But he was having his troubles.

Maybe we should go to the Perloff Committee; I would like to ask you about them. That was while you were Deputy Director somewhere between 1969 or 1970.

BROWN:

Yes. Kenny Williamson and I were secretaries to the committee, jointly.

WEEKS:

By the way, I did get to talk with Mr. Perloff the year before he died. He was very proud of his chance to participate in that committee and he had a very friendly feeling toward Dr. Crosby, didn't he? They were very close friends. In fact, I think, the Perloffs were with the Crosbys in London when he became ill.

BROWN:

I don't recall.

WEEKS:

Could you tell me what the background is on this committee? How it happened to be formed?

BROWN:

Its rationale was to look at the needs across the country for the provision of health services.

WEEKS:

Excuse me for interrupting but we can say that this took place after Medicare had been enacted and was in practice.

BROWN:

The Committee's concern was the organization of health services so that we were interested in the organization and then the financing, and particularly in financing, the where and what sources of financing. Another concern was the involvement of the government and what legislation would be needed to put in place a system that would be nationwide. There was a long discussion with experts on franchising and the big issue was -- early on in the committee -- were you going to pay attention to investor-owned institutions in addition to the not-for-profit?

The Committee did have a member of the investor-owned group by the name of Sherwin Memel. He almost resigned but Dr. Crosby and I went to Mr. Perloff and said you can't let this guy resign because if you do we'll lose the opportunity of having their input and they are really part of the whole system and they should be included. We were successful in doing that.

WEEKS:

Could you briefly describe what the system was that was recommended.

BROWN:

The system was based on a health care corporation which was an organization which would have the facilities, personnel and financing responsibility to serve a geographic area and the population therein. When

you did this, you see, depending on locations in the country, a health care corporation might be one hospital or several hospitals taking care of a geographic area. Financing would be the Blues, private insurance, Medicare and Medicaid or any other supplemental programs. Then along came the battle of HMOs and I jokingly told a group one day that's fine, organize your HMOs and we'll bring them into an HCC -- what we are interested in is assuring services to populations.

WEEKS:

Did you see the hospital care corporation as hospital-based strictly?

BROWN:

Yes.

WEEKS:

Would this be organized by hospitals or groups of hospitals?

BROWN:

Mostly by groups of hospitals. A hospital represented the financial resource, facilities and the manpower. If you take a geographical area of need for service, you may then get into multiple institutions. Take Hospital Corporation of America...what you've got is a holding company but it delivers its service through those institutions which it manages.

Or you take the Lutheran or Bob Toomey's Greenville Health System. Particularly Toomey and Samaritan have services organized as examples of health care corporations. Toomey's was better because except for two institutions, one a Shriners and the other a Catholic hospital, as I remember, they provided service to an entire county.

WEEKS:

I have forgotten now how did you plan to get around people traveling or

national corporations or in other words, if you are outside the area covered by your particular hospital corporation, how would you receive benefits somewhere else?

BROWN:

The same thing that the Blues faced. You need courtesy exchange of benefits. The HCC would have this same kind of system and since the financing of a health care corporation was really based on the existing financing system, there was no problem because you go through the financial chain anyway, i.e., from the hospital you used in Florida to your HCC in Indiana, or more often through the Blue Cross system.

WEEKS:

Did you foresee the time when there might be an amalgamation of these HCCs into a national system?

BROWN:

Not an amalgamation into one giant but a series of cooperative HCCs to cover all geographic areas. If the HCC was to be successful, it would absorb, and it could absorb anybody including different ownership. As we saw it even the investor-owned could become part of an HCC.

The HCC, the central corporation, would be interested in the standards of operation, the financial reporting, the exchange of personnel, non-duplication of services, non-duplication of equipment, and the training and education of people. Like Samaritan Health Services which provides physicians out of its system to a hospital up on the Grand Canyon in the summer time. So that's the flexibility that you have. The detractors were the pundits who said now you've got this, you are going to have trustees controlling medicine. I said not any more than they control medicine now. The organized medical staffs

which are part of the health care corporation control the practice of medicine.

WEEKS:

Did you make provisions for some sort of schedule of fees for physicians?

BROWN:

This was much debated and I said eventually we are all going to have to come down to the situation that within the HCC you are going to have to discuss with your medical practitioners what are the sensible fees for this area. You would be more like the Kaiser-Permanente. Ultimately, you ought to underwrite and provide services from that fund. But you could start with an agreement by the physicians that yes they want in and they will practice and they become your physician manpower. The HCC is more difficult to operate because initially you would not be involved in underwriting -- that is the one difference between an HCC and an HMO.

WEEKS:

Somebody else is collecting and registering the people.

BROWN:

What you have agreed to do is provide the services through your resources for a geographic area.

WEEKS:

What is at risk here? How about the hospitals -- are they getting their billed charges, or is this going to be on cost plus or is it...

BROWN:

At that time AHA was maneuvering around between its earlier philosophy of cost reimbursement and charges reimbursement. The statement on financial requirements was a charges related philosophy versus the old principles of payment for hospital care. (I was on the committee that worked up the first

principles of payment way back in 1951.) The extent to which the health care corporation became the underwriter was a problem. Of course everybody was looking at an HMO and saying they are at risk. What are you going to do if you've got U.S. Steel as part of your population? Are you going to go out and try to sell U.S. Steel Corporation direct or do you want to take U.S. Steel's contract with the Blues and take what they pay on your present Blue Cross contract?

So early on our whole philosophy was get organized. What you have is a way of making planning efficient, avoiding duplication and getting cooperation between medical people plus the exchange of people and talent without everybody trying to be the same thing.

WEEKS:

This is your big selling point, then, that by several hospitals working together they could be more efficient, could be more knowledgeable, could probably serve the people better than as an individual. So you have an administrative setup of a dozen hospitals; that corporation is owned by all the dozen hospitals.

BROWN:

They would have representation on the board. The central HCC corporation would be independent of each cooperating hospital.

WEEKS:

And pick up the administrative costs of that board according to the bed size or whatever?

BROWN:

We did not discuss that issue. Really the concept was to try to provide some guidance to getting to larger groupings on a system basis.

WEEKS:

Do you think today, after fourteen or fifteen years since you did that work, that the situation has changed? Do you think the corporation could work today as well as you thought it could then?

BROWN:

What I have tossed out to some of the staff was to take the principles of an HCC and take any one of the hospital systems today and fill them in and see where you come out. You'll find Samaritan Health Services provides services through its hospitals that it owns or manages, but not necessarily to a geographic area, complete or absolute. That was really the goal of a health care corporation.

WEEKS:

The big differences between an HCC and an HMO are, as you say, HCCs are not doing any underwriting, they are not setting up their own financing system because it is all done through a different third party. The HMO is putting the physician at risk — I'm talking about those where the physicians are a part of the ownership or part of the management.

BROWN:

That's right. A lot of the HMOs are essentially physician providers and they pay for the hospital off the side and, therefore, all you have is essentially the medical talent, not control of the hospital over the program.

WEEKS:

It would seem to me, considering the HMOs, that probably some of these attempts to make the physician independent, more independent and yet part of a group, are probably going to fall by the wayside if the premiums do not cover the cost and then they have to begin to raise the premium. Somebody is going

to say to the doctor why don't you take part of the risk like they do in HMOs. Maybe that won't be true.

BROWN:

Health care suffers now from the increasing tightening of the dollar available to do the job. Unfortunately many want to let Uncle do it. We loaded onto Medicare the chronic long-term kidney problem. Who the heck is going to pay for the artificial heart and all the rest of it?

WEEKS:

This is a good point. What are the expectations of people? Is this going to kill all our great and happy thoughts about health care for everybody?

My wife and I eat out quite a great deal and we sometimes eat a little early and we find that older people are eating about the same time. I'm an eavesdropper, I want to know what is going on. I'm surprised with many people the subject is health, what the doctor said, how many x-rays I had, how many pills I take. We come away and think what is wrong with us, why don't we take more medicine, why don't we do like these other people are doing? Maybe they are expecting too much. Do you think this is possible?

BROWN:

I think when it is all cornered down, they don't want to be deprived of anything. Pretty much we have the kind of a sentiment that if something catastrophic happens to me, it's going to get taken care of. Our scientific ability is such that we do wonders but I'm not sure that we can finance wonders.

WEEKS:

This is it. These rare exceptions. Another thing I think that's hurting us is all these TV doctor series because there the physician -- one minute he

can operate on the brain and the next minute he can operate on something else. He can do anything, work miracles and he seldom ever loses a patient. Sometimes I think many, many of our viewers are taking these things seriously -- and expect in real life that physicians can be that miraculous.

It would seem to me that in looking at the history of health care since the 1940s or earlier that there have been many committees or many commissions that do work that at the time they did it seemed to run into a brick wall. The Committee on the Cost of Medical Care, Commission on Hospital Care, the Commission on Financing of Hospital Care...many of these things at the moment they were completed and reported on just fizzled out apparently. It seems to me that many times, if you are realistic about it, this work that has been done has not been in vain but you find it cropping up -- you look at the Wagner-Murray-Dingell bill, you could say, all those four or five bills that went through and nothing ever happened, but it did happen because all the time they were generating knowledge and working out a plan. Do you think this is going to happen with the Perloff work? Do you think it's laying the groundwork for...if it never comes to being as health care corporation, do you think it's going to benefit future planners?

BROWN:

I think that if you asked that question of some of the system operators you would find some agreement or sensitivity with the Perloff report. The tragedy of our whole system is that the prideful ownership of my pup is such that they don't want to be part of a system. However, more and more of them are getting forced into some kind of group administration, so, of course, as you know, purchasing and education and training or some other components or accounting services or something else become the reason for us to cooperate.

We still aren't necessarily doing what was the great vision of the HCC which was to cooperatively get together and say we'll take care of the northern portion of Vermont.

WEEKS:

At the same time this probably included insuring services, insuring purchasing, the whole thing. Every way that they could work together they would, and this might vary from corporation to corporation according to the need. I had the feeing after talking with Mr. Perloff...he took such personal pride in having been a part of it and he felt that even though it didn't result in a new corporation being formed, he felt that they had learned a great deal and maybe it would be of great help.

I have another note here, it's a name I haven't heard of before, the McCluskey Committee.

BROWN:

The Perloff report is an independent report, not policy. What the McCluskey Committee did was analyze the principles of the Perloff report and put the principles into a statement which could be endorsed by AHA.

WEEKS:

I see. This was a reworking of the Perloff, in a sense.

BROWN:

The Perloff report was totally freelance. We told Earl (I was with Ed when we went to see Earl to get him to take the chairmanship) that we guaranteed him that his committee could work free and he would get his report. It did not have to be endorsed by AHA.

WEEKS:

One thing we mentioned just a bit was the book on planning for hospitals

which was the result, as I understand it, of a project called W59. Should we know any more about what W59 was?

BROWN:

We did a number of things in W59. It was a multi-faceted approach. One of the other things we did was an analysis of state organizations to look at their planning and everything else.

WEEKS:

It was basically a planning project?

BROWN:

Some elements of planning, yes. We had put some money into this. In fact, John Knowles, who was at MGH where we did part of the work, didn't want us to do anything unless AHA put money in the project.

WEEKS:

He must have been an interesting person, too. I never had the pleasure of meeting him.

BROWN:

He was a brilliant man.

WEEKS:

And had the courage of his convictions?

BROWN:

Absolutely. He kind of loved tearing into somebody or something to watch them cringe because he was brilliant and he was knowledgeable. I can remember once when we were in a group and Johnny was a new member and he said, "Well, all this brainpower and we aren't doing anything with it." He got carried along and was going to have them become a powerhouse in the structure of health.

One of the other members in the meeting said, "Mr. Chairman, I hate to say it but young members don't understand the precedents of this group. We are not here to try to influence everbody else we can think of, we are here to educate ourselves."

WEEKS:

We talked a little bit about the separation of AHA and BCA. I think part of it was off tape.

BROWN:

I think the quick summary of that was that when the Blue Cross plans determined they needed a better organization...they already had a framework as part of the articles for the Blues, in the recognition of the Blue Cross Association. It was recognized that if the Blue Cross Plans were going to get into further organization and merchandising, they needed to get about it. It provided a background for them to become the strong intermediaries in Medicare. What AHA lost or turned over was the approval program, which it had carried. AHA was really the sponsor of the Blue Cross Plans for years, not without some feuding and fussing, of course.

WEEKS:

They probably made Blue Cross able to progress as rapidly as it did because they were out beating the bushes.

BROWN:

You find people of that early group and the administrators in my age group who knew and understood the principles and purposes of Blue Cross. You jump that by twenty and thirty years and the attitude of many of the administrators is that's just another source of financing, they didn't understand why you took a cost formula.

WEEKS:

Or the fact that Blue Cross was selling service rather than indemnity and it made a big difference. Going a few years before Medicare was enacted, wasn't there some jealousy or some feeling among some of the Blue Cross people that they should get away from AHA?

BROWN:

Yes. There always was the tendency among some of them and this was particularly true where the negotiations between the plans and the participating hospitals was rough. Then, of course, there were the plans in which the Blue Cross discount was rather substantially based on billings and yet the largest protection of the population in that area would be Blue rather than insurance. So they proved a point, but it didn't always make it easy financing for hospitals. It was part of the game.

WEEKS:

John Mannix once made the statement to me, when he was looking back at the early days in which he was helping organize the Cleveland Blue Cross Plan before he became a part of it. At the same time there were six other plans within a period of eighteen months that were started and formed and he didn't know any one of the other six managers and they didn't know each other. Here they were starting out and most all of these people were not hospital people. Most of them could have been anything from selling real estate to any kind of management. Is it possible that in those early days they had some prima donnas, some entrepreneurs that were in there working hard to get something started and didn't want anybody to interfere, was this part of it?

BROWN:

Very definitely there were a number of very good entrepreneurs. The other

thing is that the plan depended so much upon that individual. Take van Steenwyk, he started in Minnesota and later went to Philly. And in each place he was developing, he planned. The strong and the large plans had people of considerable abilities, not only supporting the principles of Blue Cross philosophy, but very able administrators in their own right. I felt at times, they leaned pretty heavily on the AHA endorsement.

WEEKS:

There may have been another factor there, too. The boards were without experience, too, in these new plans and maybe after they became experienced, some of them felt they should be more independent of AHA than they were. Of course, this is a just supposition.

BROWN:

Yes. The out-of-area benefits, the percentage of payment which was difficult for some of them, the percentage of reserves -- your Michigan plan was always in jeopardy becase it rarely had enough reserves.

WEEKS:

Something like $10,000 initial capital.

BROWN:

But it delivered a hell of a fine product.

WEEKS:

Many places had to have state laws passed to allow them to operate differently from insurance companies.

BROWN:

Yes, special enactment. And that was much sought after. Then if you wanted to broaden the benefits, you ran into trouble because you were a hospital plan and not supposed to be giving ambulatory benefits. So it worked

both ways for them.

WEEKS:

Dr. Crosby died in 1972. Had you any warning at all, was he in bad health?

BROWN:

He had been under the care of a physician for quite a while. He was very secretive about how ill he really was until he became ill in England and came back. He went to England after we had had the January meeting in Washington. Ed never talked about his condition and he wasn't going to let me in on it.

WEEKS:

I never knew Dr. Crosby. Of course I had seen him at meetings and things of this sort. He wasn't a back-slapper type of person was he?

BROWN:

No, he was very surprising in that staff often felt that he was kind of distant, but Ed, out of his own good resources and in talking with other people, would learn a great deal about a person. He never gossiped about it, but he knew and understood his people very well. He was not overtly gregarious. He was respected for his ability and his knowledge and had his own close friends and that served him very well. Quietly, he got a lot done.

WEEKS:

I know that during his tenure the building at 840 North Lake Shore Drive was built and a lot of things like this were done. How would you rank him as a hospital association executive?

BROWN:

Ed was not like some of the others because of his own inimitable style. When I joined him in 1956, I walked into his office and he threw the plans for the headquarters building out on the desk and he said, "That's your first

job." So actually, in my association with AHA, I was project manager for both buildings.

Ed tended to be very close to some members of his staff and then just even-steven with everybody else. Your life was much better if you were in the even-steven group than if you were in the very close group because he leaned on you awful hard. Sometimes not realizing that he was compromising the time that you might have with your family in order to get your own work done. He did this in getting his own job done. I felt that he wasn't thoughtful enough about the fact that he had leaned pretty hard on some people. Overall, he was a great leader, very capable and creative.

WEEKS:

I have been told that you are probably closest to him of anybody on the staff.

BROWN:

In the staff, yes. In friendship, Russ Nelson was the man. Russ and Ed were very close.

WEEKS:

They were both at Johns Hopkins together, weren't they? I think I have heard that Nelson was in London at the time that Crosby became ill.

BROWN:

I guess he went to an IHF meeting over there.

WEEKS:

Yes, I guess it was an IHF meeting. And I think Perloff went along for this reason probably.

I think I asked you off tape what you thought it meant to have an MD as head of the association since you and he were the only two since Caldwell left

in 1943.

BROWN:

This is a very sensitive problem. The majority of AHA leadership has been, in recent years non-MD. Some don't have very good feelings about physicians as administrators. There was an article in the ACHA journal a year or so ago about why persons with MDs aren't good administrators. It was a little bit self-serving. My philosophy has been that the administrative ability is not necessarily whether they are MD or non-MD, it's the individual. What Ed and I, to a certain extent, brought to the association was the physician's philosophy in terms as it related to administration. At times we were probably not the best friends of the AMA. In fact, I think the current administration and the more current officers that have gone through have probably done better with the AMA than we did -- Snoke, Crosby and a few of the others used to scrap with the leadership in the AMA. We shouldn't be complimented for having scrapped with the AMA -- really you have to get along and get the job done.

WEEKS:

In other words you are saying that it is the individual rather than the title or degree that probably made the difference. It just happened that you and Dr. Crosby were MDs. I was just under the impression that the fact that you and Dr. Crosby were in there made for better relations with AMA, you had a better chance of fighting on equal ground.

BROWN:

Being administrators by function, we were group dynamics persons so at times we would get impatient with the physician who was sticking to his individualism rather than trying to understand group dynamics. You have to

get some collectivism in your thinking. Another concern was the humanizing of our staff and being very careful about hiring staff which had had some contact, preferably work, in the institutional field. You can talk all day, but if you haven't lived it, there is quite a lot of difference in your sensitivity to the place.

WEEKS:

I sometimes think the same thing is true of teaching. So many of the young faculty members haven't really had much contact. I realize that is not the only attribute that enters into a good teacher.

Of course, Crosby also had his previous experience with the Joint Commission. Now you served on the committee, didn't you, that worked with it?

BROWN:

On the Joint Commission, AHA had six representatives. I served as staff for what we called the Committee of Commissioners. I did the staff work and counseling with the Committee reviewing the regulations the Joint Commission was proposing and this kind of thing — reviewing with committee what did we think about what ought to happen and what shouldn't happen.

WEEKS:

After the American College of Surgeons felt they had to drop their original quality plan and AHA offered to take it over completely if no one else wanted a part of it, what happened?

BROWN:

You mean when JCAH was born?

WEEKS:

Yes. The AMA reacted quite strongly to that as I understand it and then wanted a part of it and then of course the American College of Physicians and

the American College of Surgeons. Was there any vestige to the feeling of opposition by the time you got there or had they pretty well gotten over it?

BROWN:

Often in the debating society of the Joint Commission, invariably the AMA took a position different from the AHA. To get certain things done, the success came when ACS and ACP agreed with AHA then we could get something done. But most of the time you got divided up into committees and I can remember working eighteen months to get the term medical administrator, as used by the Joint Commission, accepted. We had the AMA, AHA, and JCAH attorneys talking, talking, talking. I had some trouble with the AHA guys. One said, "My staff isn't going to tell me 'no' if I want to remove a pathologist."

I said, "Wait a minute, if you wanted to fire a pathologist, would you fire him, and for what reason? The cause should be administrative."

"Yes, but could you fire him if he is a member of the medical staff?"

The answer was, "I always go and talk with the chief of staff and the chairman of the department." I said, "That's the whole point, gentlemen, AMA wants to be sure that just because you are mad at John Doe, you aren't going to fire him without a sensible hearing and all the rest." It was a contest between what was an administrative staff prerogative and what was a medical staff prerogative. And there wasn't going to be any gray. This was going to be a hard and fast rule.

I just asked one of our administrators one day and he said, "No, I go talk with so and so."

I said, "That's what the whole battle's about. The medical staff leadership should know about it and participate in the discussions. You

didn't do it bingo, without the courtesy of saying we're in trouble.

WEEKS:

. It all gets down to a few words sometimes, doesn't it?

BROWN:

Always, and they are cliffhangers. This discussion went round and round. The poor attorneys, I don't know how many times they recouched their words. But I think they understood the issue but they couldn't crack the personalities.

WEEKS:

Would you like to speak to what happened and why McNerney didn't get the job as chief executive of AHA to succeed Dr. Crosby, and why McMahon got it and how many search committees there were?

BROWN:

I'll tell you what little I know about it. There were two search committees. The first one recommended Walt McNerney. The reaction was negative in the hospital field. Walt had made some of his very fine talks in which he was pretty caustic about hospitals and implied that hospital administrators were not good chief executive officers. That resulted in having a second committee. I was not privy to any of it. Nobody on staff was. The secretary of it was a member of the staff but you'd never get anything out of him and I don't think he ever ought to be asked to do it.

Alex McMahon had come to light. Alex was on the Blue Cross board. He was well liked by administrators down in his section of the country and he was known to the members of the second search committee. The only role that I played in it was that I went out to O'Hare Airport to pick him up and brought him down to the hotel. But I didn't even know that they were considering him

until then. They had asked me, as had the first committee, did I want to be considered. I said considering my age, that is not what ought to be done. Suppose they wanted me to do it. About the time I stepped into office the leadership would need to have another committee to start looking again. I said AHA needs somebody who has ten to fifteen years of developmental time subject to the will of the Board. That was my contribution to it.

I was complimented to be their acting president but quite honestly — I remember I called all the administrative staff together and said, "Now we've got a job to do until whoever is going to be our new boss is selected. You are going to work harder than you have ever worked because we are short a few hands."

There was one position that I asked to be made firm and that was when Kenny left I wanted Leo Gehrig to head the Washington staff. I asked for that to be firm. To the other executive staff I said, "We're not going to make any 'actings' of this or 'actings' of that or people in special cozy little places because we must remember that the new man must have the prerogative of creating his own staff."

WEEKS:

I have a feeling that Kenny thought he ought to have the job. Did you ever have that feeling?

BROWN:

Oh, I would think probably Kenny did. Kenny, you see, was there longer than I.

WEEKS:

I think Kenny was the first so-called executive that George hired in 1943 or '44.

BROWN:

I know he came out of California.

WEEKS:

What was the Williamson incident?

BROWN:

Again, I was not involved, but it was a discussion between Dr. Crosby and the officers.

WEEKS:

This was done before Crosby died?

BROWN:

Yes, the discussion was with Crosby before he died. Kenny left after he had died.

WEEKS:

Was Steve Morris the chairman of the board or president or...

BROWN:

Yes. He was chairman.

WEEKS:

I have heard stories. This is a story I heard, I don't know how true it is. Kenny had become persona non grata in administration because he had been out making speeches in which he had said some slandering things about Richard Nixon and that some of the officials, I would assume Morris included, objected very strenuously to that because they were strong Republicans.

BROWN:

I just know that Kenny didn't hold Nixon in very high regard and that he used to call him "Tricky Dicky." But the thing you cited, I know nothing about. When I moved in as acting president, I was meeting with the three

officers and they said that this had taken place. They had been discussing it with Dr. Crosby and since Ed had died, they thought it best that they complete the situation.

WEEKS:

Did you agree to handle the problem of telling Williamson about it?

BROWN:

No, I was not asked to do it.

WEEKS:

I was thinking that it would have been a very embarrassing situation for you if you had had to.

BROWN:

You see, I didn't know anything about it -- or what the whole tempest was about. I didn't know and after the whole thing I didn't go back to find out. It was embarrassing for people and once a harsh decision has been made it is better to let it lie.

WEEKS:

What kind of a man is Steve Morris?

BROWN:

Steve Morris was the assistant at Good Samaritan and then became the chief executive when it was essentially just about one institution. He is a course graduate, I think of St. Louis. A very intense guy in his administrative behavior and very careful of his prerogatives. Knowledgeable, persuasive, but if it's his responsibility, he can get dictatorial. He is a very capable man. He was at times on thin ice because he ran a pretty big empire and did quite a lot of capital development. Trustee interests in town disagreed with him but he lived through that. Overall he is a very capable man, a leader in

his own affairs.

WEEKS:

I have never had the pleasure of meeting him.

Since we are talking about Washington, up until the time that Williamson left, he was really the principal representative in how the association in Washington worked, wasn't he? I'm using that in what I think is a change in role. I look at McMahon, as example, spending probably as much time in Washington or in government affairs as he does in running the shop. In other words, I think there is a chief operating officer besides. Am I right in that?

BROWN:

That was all part of the planning and the programming at the time Alex came to the Association.

WEEKS:

Crosby himself didn't act that way, did he so much? He wasn't so active in Washington?

BROWN:

Kenny and some of the members of his staff did pretty much all of the day-to-day liaison. Ed went down and did a fair amount of testimony with officers and he did a lot of his own private talking with members of government. Kenny had the burden and sought to do it — wanted to do it.

WEEKS:

And could open the doors when somebody needed to go there. Somebody explained that possibly if the president goes too often, he is over-exposed and maybe it's better if you have a competent person in Washington to bring in the big guns only when you need them.

BROWN:

It is very much a matter of judgment on who to use and how to use them. But part of the changeover in administration was that the officers felt, backed up by the Board, that the chief executive officer should do more of the cultivating.

WEEKS:

This is understandable and a whole lot depends on the personality of the person doing it. As an example, George Bugbee talks about lobbying in Washington as about the worst thing he could do. He hated it more than anything else. I think he was effective but he didn't like it.

BROWN:

And, of course, the tempo -- the tempo between George's day and Alex's day is like night and day.

WEEKS:

Beyond reason now. I don't know anything about Dr. Gehrig. Can you tell me anything about him?

BROWN:

Leo had been in the federal government. He was a Public Health Officer and one of the undersecretaries. A very calm, strict disciplinarian, very well liked in Washington because he was calm, he stuck to his words, he never misled you, he did things on an even keel. He called me up one time to discuss the problem of investor-owned interests and ours. I said that in our testimony, we ought not to try to make a sharp difference between AHA and the investor-owned federation.

He said, "I understand."

I said, "Because we aren't all that different, we do operate differently

but I don't want to make a big clash of it."

No problem with Lee. Lots of problems with Kenny. Kenny felt that the only field should be the not-for-profit. I've seen him take on the fort several times. It didn't come out that way. Because of Leo's long contact, he had a lot of contacts among the full-time staff in Washington. They knew him, had worked with him, and he could communicate with them. I was very pleased to have him. As I say, that was the only appointment I wanted to make firm and I took a risk because, of course, Alex could have changed it.

WEEKS:

Did you stay on longer than Gehrig did? I was wondering if you were there when Jack Owen was apponnted?

BROWN:

Leo was still on staff when I retired.

No. Jack came on after I retired.

WEEKS:

He is another person I have never met.

BROWN:

Jack Owen worked at AHA before he went to New Jersey.

WEEKS:

He seems to have done a very capable job in New Jersey.

BROWN:

Yes. He is a very able man and I would say he is one who likes association work and is very able politically.

WEEKS:

He was a good appointee for that job.

Now your period as Senior Vice President. John Mannix said that you

probably made some of your greatest contributions while you were vice president for the last four years there. I have you down for a committee on physicians as secretary from 1973 to '76. Was that different from previously?

BROWN:

In those last three years I had lots of fun because I was secretary of the Committee of Physicans and Secretary of the Committee on Hospital Governing Boards. It was interesting. Tom Ainsworth was the man who developed the first committee. The philosophy with them was: Gentlemen, you are here as though you were members of the medical staff and we're dealing with you and with administrative problems and that's the way we ought to think about ourselves. The physicians represented all kinds of practices — group practice, professors, Mayos, general practice, a clinic out in Idaho, a pediatrician from Louisiana — all very capable men.

We had two members who were nominees from AMA. We had some very good representatives. The best ones were the men who had been chief of a service, on the medical staff executive committee and on the hospital governing board. They knew what you were really working for.

I got down to where I was writing some white papers on medical staff, board, and administrative relationships. Everybody was worried about the communication between the board, administration, and the medical staff. My philosophy was you make it simple because you do it through the committee structure.

WEEKS:

What were the objectives of this group?

BROWN:

The major use of the committee was really a ventilating mechanism. It

never got to be manuals or anything like that. When I wrote the piece on the involvement of trustees on committees, I tested it out on the chairman and we gave it to the committee the night before the meeting the next day. When I came in the next morning, several of them looked at me and said what are you worried about, we've been doing this for five years. It went next to the Committee on Governing Boards.

BROWN:

It was during those three years that we finally got acceptable verbiage to add members of the medical staff in addition to other physicians as members of the governing body.

WEEKS:

These people on the hospital governing board committee, were they all trustees?

BROWN:

It was about a fifteen man committee, with one state exec, one administrator, and several physicians. The requirement was that the physicians had to be members of a governing board. The majority of the committee were dyed-in-the wool operating trustees.

WEEKS:

This comes to a point which comes to the fore again. In fact, I just talked about it with Dr. Frist from HCA. Did this committee take any position on whether a physician should be a member of the board or not?

BROWN:

Yes. That was one of the things we hassled out. The feeling was, okay, the chief of the staff might come and sit with the board but that was all that was needed. I don't know how they feel now. Personally, physicians as a

philosophical and knowledge entity should be on the board. Everybody kind of thinks they ought to have representation on the board. After you get into it deep enough you find out that it isn't the easiest or the nicest seat to take. But physicians and representation from the medical staff should be there. In order to make this thing work was why I suggested the approach of the exchange appropriately of representation on certain of the administrative, medical staff and board committees. This way the philosophies can flow and they understand the responsibilities when you sit with the medical staff or when you sit with the administrative staff there is less problem when you try to get things understood.

My experience has been that some of the worst clashes are not that it was right or wrong but that people misunderstood what was trying to be approached.

WEEKS:

Was there much discussion about the responsibility of the trustees? You mentioned one board where the trustees seemed to be working very well...I don't know whether it was Hahnemann or Roosevelt where you said you had a big board....

BROWN:

Roosevelt.

WEEKS:

My only experience, exposure to boards was in a smaller hospital like 150 beds or something. It seemed to me that this particular hospital had a corporation set up so that you could be a corporation member if you paid a dollar a year or whatever and then you had a right to vote for the trustees and then it became a popularity contest. There were many people elected to board positions who were not capable by background or experience and didn't

understand the responsibility that went with the job. They figured it was sort of an honorary position that was recognition of your popularity in the community.

BROWN:

Or, perhaps, you will leave us $2,000,000 later.

WEEKS:

Yes. Something of that sort. Was there much effort made to talk about the responsibilities of, the corporate responsibilities of...

BROWN:

The overall general area of the responsibility of being a trustee was discussed. Putting it down and making it live, or trying to get it accepted, never really succeeded. With that I would say that you can read MacEachern or any number of kinds of text and find out the classical descriptions of trusteeship. Probably the most beneficial things are coming out of the Trustee magazine and the column of the chairman of the committee.

Medical staff appointments, tenure, are being discussed. The big difficulty is that in the 50, 75, 100 bed hospital, critical to human care in a lot of our rural states, a trustee lives by his wits and realizes that at times things are getting compromised. The worst problem is that they don't know how to deal with the physician who is a problem. He represents too many bucks. This is why I used to love to go to the state hospital association meetings and go to the trustee sessions. They would light on you and want to know some quick solutions. I said there isn't any simple answer, there are consultants for it and you can make as much as you want to out of the Joint Commission visitation or you can get a consultant in, but if you want to use it, you have the power. However, you know very well that consultants or you

can cause one heck of a lot of problems.

In many of the institutions, the solvency of the institution depends on one or two or three physicians.

WEEKS:

I have often wondered about credentials committees...if they really did an excellent job, the hospital would be in a pretty good position but if they don't do an excellent job, they could be...

BROWN:

You said it. The physicians that are apprehensive say, this is only a medical staff proposition. My philosophy is, if you want to get on our staff, I want two copies of your application. One goes to the credentials committee. I look at the other one and I have my channels to go through for references. In talking with the committee on physicians, we went through this, and in the Joint Commission. Just because a person has the right set of tickets, you don't know what kind of guy he is until you do some other kinds of investigation.

WEEKS:

It is a tremendous responsibility, this credentials committee because once you get a man on staff it is awfully hard to get rid of him. You may end up in court. On the other hand, if you don't get rid of him, some of your people may get slaughtered.

BROWN:

That is true. The important thing in doing surveys for the Joint Commission, I found that too often physicans did not understand. They believed the medical staff should be self-determining. I asked a man one day, "You're now chairman of the medical staff executive committee, was there ever

any acknowledgment by the board of your appointment?"

"No, no, this is a medical staff responsibility."

I said, "Wouldn't your job be easier if the medical staff knew that the board knew that you had this job?"

He said, "I never thought of it that way."

So I spent my time trying to make both sides understand how by reenforcing one another intelligently they would all come out better. The medical staff is frequently under a lot of pressure and if the board comes along and senses that decisions are mostly political that board member is in a tough spot. If he is sitting down and listening to the committee struggling with credentials plus defining the privileges of a physician then he is very much more sensitive as to how the medical staff is behaving.

WEEKS:

There is no question in my mind that this is one of the greatest responsibilities a board of trustees has is approving privileges yet some of them don't seem to realize it. They say we'll just turn this over to the credentials committee, Dr. Smith knows more about it than I do and if he says okay, we will say okay. But I think I agree with you, I would want a second copy that I can study for myself.

BROWN:

The problem is that for many this isn't any business of the administration. My mix of being a doctor was where I had something to contribute. Hopefully the committee would say now you've got your avenues, you go check your things, and let us check ours. I would surprise them sometimes. Do you know that this guy who is a good friend of yours is in trouble in the hospital? Oh, he never told me anything about that. I said,

"Let's both of us find out about that -- go a little slower." I have always found that physicians, if you explain to them, they behave better. Rather than saying it says in the bylaws that that is my job, let's look at it together.

WEEKS:

I learned a lesson early. I had one case where I was consultant on working with a search committee searching for an executive of a state association, not hospital association, but related health association, and I interviewed eight or ten men. I had a feeling about the man that I thought that they were leaning toward. I talked with him and I tried to find somebody that he knew that I knew. Finally in the conversation, I did. I went home that night and I called our mutual acquaintance and he said, "Well, the applicant is a very talented guy." He brought up some of his public relations work and this kind of thing -- "But did you know that he is an alcoholic?" I went back to the association and said I wouldn't recommend this man he's talented but he is an alcoholic. He could ruin your association if you had an annual meeting and he got drunk and misbehaved while drunk." I learned something by using a telephone, sometimes a man will tell you something over the phone that he won't put in writing.

I haven't had another job like that but, if I ever do, I'll remember the telephone, and I'll follow my intuition.

BROWN:

Reference letters at best are often rather general.

WEEKS:

And, if said over the phone, there is no real way of proving what you said.

What do you think the future of JCAH is? I was wondering if at some point

they could ever take over the PRO job. I realize that the way they are set up now these are individual organizations. There could be several hundred, I guess, in the United States. But what other kind of quality assessment have we? JCAH can give us a general picture of what a hospital's facilities are and how their record keeping is, and so on. I just wonder if there is ever going to be one organization that will work out the details of what quality assessment should be, that PROs can use or I guess there are still some PSROs.

BROWN:

I worked on Paul Sanazaro's committee. If you look at the East and West Coasts and the differences in practice styles -- you never get a match of understanding.

I think the Joint Commission's greatest value is to beat out uniform national standards. Granted that these are predominantly in the area of, let me call it, process, not quality judgment as to whether that appendectomy was done in fine style, but you can check out whether they had a tissue report and several other things. That is a great contribution because from East to West Coast at least within that organizational entity you are striving to have the same standards whether it is the East or the West Coast.

Now, the weakness we get into -- they've done a lot to improve this -- is the difference of interpretation or interest of the surveyors.

Madison Brown, when he was surveying for the Joint Commission, which I think was a very good experience for me, was probably more interested in the administrative aspect. I could look at enough charts and records and everything else to get at the proper recording of care, but I wasn't as interested in that as the admitting procedures and, when they come to the OR, did they have an anesthetist's note on it, did they have all of the lab work

and this kind of a thing? Go down in dietary, or you walk through the kitchen -- and observe the cleanliness. So I was probably harsher on them in that than I was in the clinical sense.

But here is one organization, it is national, it is supported by national organizations and I think it is doing a good job. The JCAH cannot, in my opinion, get over into the PSRO business, nor can it get into doing a lot of individual preventive work or resolution of problems in individual hospitals.

I would be asked, we've got trouble with Dr. So and So. I say, all right, I'll give you three names of people who can come down here and help you and audit this person's work and help you make a decision. The JCAH can't be judge and jury too nor deal with individual staff situations. Some hospitals thought that was kind of queer but I said that isn't what our business is. And I don't think it has changed.

WEEKS:

No, I don't think so either. I think I would agree with you on that.

Your wife was talking about the Society of Medical Administrators. Tell me about that and how do you define a medical administrator. Is this the administrator of a medical staff or is this an administrator who happens to be a medical man?

BROWN:

It is an administrator who is an MD. It began way back in 1909 and at that time they were the MD administrators, predominantly in the East Coast hospitals. Then World War I came along, there was a hiatus and they didn't get very much done until 1919. Then they became more formally organized. For years, the members were all hospital oriented. Later they began to worry about some people in education, and they ought to look at the

Kaiser-Permanente boys. In the last fifteen years the additions to membership have been delightful because they were the chief executives of the Joint Commission, the Council on Medical Specialty Societies and somebody from the AMA staff. We've had Surgeons General from the armed forces, the VA, and Assistant Secretaries of health. Also, some of the members have gone from the voluntary non-profit field into the proprietary consulting business.

WEEKS:

Is the purpose of this to exchange ideas? Much as any other professional association would be?

BROWN:

Yes on both questions. They are concerned with the dilemmas of operating a whole lot of things. Recently, reimbursement has been a major topic.

WEEKS:

Another group I was interested in, and hadn't heard of, is Hospital Administrators Correspondence Club.

BROWN:

This is a group that had started years ago and again, the hospital was significant -- the name is significant - and it is like all of the 52 clubs. Each member wrote an article each year which he shared with everybody. I am one of the delinquent boys who quit contributing. But they won't kick me off the roster which they ought to do. Some are original contributions and very interesting. Others always clip their latest contribution to some journal. It has worked both ways.

When I was doing it religiously, I always tried to think up something that I wanted to talk to the members about -- rather than to use one of the things I had had published.

WEEKS:

This probably had more value because you were talking about a point that they would be particularly interested in.

I know you are a Fellow in the American College of Hospital Administrators. Have you entered any of the activities in the college?

BROWN:

I haven't been involved in the College for fifteen years, I guess. For a time I was involved in the structure of the examinations.

WEEKS:

Every now and then you run across someone who says, if it had been handled right there wouldn't be any American College, it would all be in the American Hospital Association -- too much duplication. I realize there may be some duplication as far as seminars and this kind of thing is concerned but what do you think of them as separate organizations, does each have its role?

BROWN:

Yes. You see, to me, the College has the opportunity to treat its membership as chief executives. AHA, in contrast, has a lot of administrative staff CEOs, but it is dealing with dietitians, nurses, engineers, pharmacists, and so on. That is not in ACHA's basket.

One of the other things is, if you look down the roster of presidents, there were one heck of a lot of MDs in the early days. There was a lot of sensitivity that doctors were dominating this.

WEEKS:

There hasn't been a physician since George Graham back in 1969.

BROWN:

The philosophy swung the other way. The MD talent is being used by the

Association of American Medical Colleges. That is where your MD talent has gone. There are some physicians in AHA's structure — not to the extent it used to be.

WEEKS:

I notice you have been doing some work in the Veterans' Administration.

BROWN:

I got into that because Joe McNinch, when he retired as Surgeon of the European theatre, was known to Crosby. Crosby got him to come to AHA and Joe was director of research for us. Then Congress got anxious that this great talent wasn't being used right and so they had a special enactment and he became medical director of the VA. Joe and I had worked together and had gotten along fine at the AHA and he had me appointed on the special medical advisory group. I had the nice privilege of being there six years instead of five because Roger Egeberg got drafted for work by the government and they made me chairman, then the next year they asked me to stay on and be chairman again.

WEEKS:

This Education Commission for Foreign Medical Graduates that we were speaking of...When I talked to Dr. Millis he made the point that the picture was changing a great deal now with foreign medical graduates. That even though you set up an examination for them coming into the country, that there might not be any residencies or internships open because of two things. One, the increasing number of American graduates and two, the decrease in the number of residencies and internships. Is this something that you run across?

BROWN:

ECFMG does nothing in placement, but we are aware of this. The other

thing you have to remember when you are talking about foreign medical graduates is that a substantial number of them are citizens of the United States. Foreign medical means they graduated from some school not in the United States, Canada, or Puerto Rico. Originally it was the Educational Council then, typically U.S. style, we had a Commission for Foreign Medical Graduates to do a special study on their problems. The two organizations got together, the council and the commission, to share ideas, one of which was they ought to merge. My contribution was okay you've got a logo, ECFMG, and if you change the council to commission you symbolize fusion of the two organizations.

Now ECFMG gives the only examination. There used to be the ECFMG examination and the VQE -- the visa qualifying examination. There is now an examination which supersedes those other two. We gave it the first time this July.

Of course, we also give an English examination. We give it to people even from the United States, much to their resentment. It is hard to believe that 10% of the U.S. citizens won't pass English exams. Many go somewhere where they are taught in Spanish and they don't use English. Their phraseology and their understanding fall off very rapidly.

WEEKS:

I interviewed Dr. Montague Cobb. I don't know whether you know him or not. He was at Howard University for years and years. He is a physiologist...a very eminent man in his field. He told me a story, I can't repeat it because I can't remember the words but he was trying to tell me about a young black intern who was talking with, examining a young woman, a black woman, who was pregnant. He asked her questions voiced in his level of

the English language and she didn't know what he was talking about at all. The older man, Dr. Cobb, was listening and he said maybe I could ask her a question and he used some of this deep South Black slang and language and he immediately found out how she got pregnant. But the other man wasn't getting anywhere. Even in this country, as you suggest, you may not speak good English.

Have you any thoughts about the future? What are we going to do? You have had a lot of years in this medical care/hospital care system -- maybe I should preface this by saying, I don't know whether you read an article in the Wall Street Journal yesterday which said that the government was going to have to cut back on entitlement programs but it wasn't the entitlement programs to the poor that were so much in need of revision as it was the entitlement programs for the middle class. So this brings me to a point of what are we going to do, we talked about expectations a while ago -- here we are back to entitlement programs. What do you visualize as our system of delivery of health care in a few years down the road?

BROWN:

I think we are mixed up in our sense of values. Wait until you get down to who is entitled and who should be entitled. If you take Social Security...Social Security had a purpose, let me identify it as an income supplement. Then health got grafted on to Medicare, with very poor judgment as to how much all of this would cost and to some it looked as though we had better take care of kidney disease and so we added a cool billion dollars right there. As I said earlier, we can do more in medicine and we all tend to expect it to be ours, or it ought to be done. The costs of it are not ever really thoughtfully examined.

We haven't even decided sensibly as to whether we are willing to devote ten percent of our gross national product to health. You should not just say to health, you need to define what you want to do. Now you look at it sociologically and maybe there is a reason to question whether millionaires and billionaires, and we are making more millionaires than we know what to do with, I guess, should be entitled dollarwise to the same kind of benefits that somebody else really needs. Then we are faced with, "Oh, so you are going to get down to the hard bench and inquire as to how much do you make or don't make and are you entitled to all of this?" -- and so on. I don't see how you are going to make these evaluations -- let's say like Germany -- the last time I remember they are spending about 10% of the gross national product -- are we willing to spend 10%?

When Tom Tierney was in Social Security and I was at AHA we used to cry on each others' shoulders and say the damn guys are stealing us blind. I said, "You know who is stealing you blind, don't you? It took so long because it had to go through the Department of Justice." But we do have bad actors and the penalty should be very, very severe -- probably out of proportion to the dollar. Just the principle that you are invading and endangering a whole social system by your lack of ethics. Otherwise I think we'll do the great American show of muddling through and try to figure out ways to chip off and cut down and revise formulas and somebody else will find some new thing rather than DRGs to do something else for some reason. We have never really taken some assumptions and tried to figure out how are we going to handle it.

We were talking this morning about how did we get into Medicare and Medicaid. The AHA, Blue Cross, AMA, and several others analyzed it and we said okay this is fine but we need to have the government take care of this

and this. So off we went. Then the government was surprised. When they began to pay physicians we learned about how much free work they were doing. My brother-in-law said, this man is getting $250,000 a year out of Medicaid. I said wait a minute...that's a nice newspaper story but he is probably one of a group of physicains. Should he get $25,000? Go ask your personal physician what he makes.

You know our sense of values and our crisis comes on us when we need help. But as a group we have never sat down and said, "American public you can't have it all." One of our greatest sources of research is the damaged child, the imperfect baby...the Jane Doe incident. Those parents had great, great courage. But you see, every time we say you must do everything we know about technologically and humanitarianwise, we don't know what we are asking for in dollars. There is some finite limit I think to what the public might say should be the limits. However, tomorrow one of them gets hurt -- and you will see they expect the fullest spectrum of care. I don't know how we get away from it.

WEEKS:

This is the difficult part.

BROWN:

You see, England doesn't worry about PSROing.

WEEKS:

I don't hear too much quarreling with England's system to tell you the truth. They have more general practitioners than they have specialists or consultants, as they call them.

I'll tell you a little story. I met a man from England, a general practitioner up in Yorkshire. A couple of years later he came to Michigan and

he stopped to see me. I invited a general practitioner from a neighboring town, a friend of mine, in for lunch and three or four of us sat and talked. I thought they would enjoy meeting each other. This was twenty years ago. We talked about his work. He worked in Yorkshire and there were four MDs that worked together so they could spell each other off for vacation and this kind of thing. Here he was making a trip to the States, being gone three or four weeks, and his colleagues were covering for him. At this time, twenty years ago, forty thousand dollars was quite a lot for a country doctor to make. So my friend had a vacancy in his office, there had been four of them practicing together and one man had gone into industial medicine and they were looking for another man. So he said to the Englishman, "How would you like to come and work with us." He described what he had, and so forth. He said, "How much do you make over there in England?" The American wasn't hesitant. The Englishman said, "About $7,000 in American money." He said, "I make about the same as my friends the attorneys and engineers, my social friends. I make about the same."

My friend said, "I could guarantee you $40,000 a year here -- just come over, join our group."

He said, no thank you, I am not interested. He said, "I like my life -- I like the way I live -- I like the office -- I like the people, patients, colleagues. I'm satisfied."

The American couldn't understand that at all. Here he was offering the doctor almost five times what he was making over there in England.

I think that all of us, if we can make enough money to live the equivalent to what our friends do, I think most of us are satisfied -- unless we move into another social group.

BROWN:

Of course, our comparisons are so often a dollar exchange. You do find when you take a unversity like this one in Vermont -- they don't pay as much as they do out in Michigan -- but the life style is different and so most of the happy and the successful faculties here are those that like the lifestyle. And have tailored their lives to that dollar level.

But I used to listen to my administrative friends, particularly the young ones -- I see you changed your job Charlie -- well, I'm getting $10,000 more there -- they'll pay me what I'm worth. Just skipping around the world.

WEEKS:

Rather than taking an interest in what they were doing probably.

BROWN:

And making a contribution to whatever. To me a job is making a contribution.

Interview in S. Burlington, VT

June 21, 1984

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